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Web site: www.nedelta.com



Preferred Provider Program

ENROLLMENT / CHANGE FORM

PLEASE PRINT LEGIBLY OR TYPE - IN BLUE OR BLACK INK ONLY
AS YOUR ID CARD IS GENERATED FROM THIS FORM

NEDD USE ONLY

DELTA DENTAL PLAN
OF MAINE

Mail completed form to:
Employee Health & Benefits
114 State House Station
Augusta, Maine 04333-0114

1. SUBSCRIBER INFORMATION - To be completed by Employee

LAST NAME (SUBSCRIBER)	FIRST NAME	SOCIAL SECURITY / I.D. # — —	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH — —
MAILING ADDRESS		CITY	STATE	ZIP
				TELEPHONE NO. ()
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Other _____				

2. GROUP INFORMATION - To be completed by Employer/Employee

State of Maine	114 State House Station, Augusta, ME 04333-0114			
GROUP NUMBER 0601 / 0551 / 0602	SUBLOCATION NUMBER	DIVISION	DENTAL EFFECTIVE DATE — —	
MISC. INFO (i.e. STORE LOC)	EMPLOYEE DATE OF HIRE	EMPLOYEE DATE OF REHIRE		

3. REASON FOR SUBMISSION - Check all appropriate boxes

EXACT DATE OF STATUS CHANGE: _____		MISCELLANEOUS CHANGE:
ADD:	DELETE:	<input type="checkbox"/> Name change – Previous name: _____
<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Annual Open Enrollment	<input type="checkbox"/> Transfer from sublocation _____
<input type="checkbox"/> Annual Open Enrollment	<input type="checkbox"/> Spouse's employment change	<input type="checkbox"/> Address change
<input type="checkbox"/> COBRA Due to: _____	<input type="checkbox"/> Full-time to part-time status	<input type="checkbox"/> Returning Full-Time Student
<input type="checkbox"/> Marriage	<input type="checkbox"/> Divorce	<input type="checkbox"/> Other _____
<input type="checkbox"/> Birth <input type="checkbox"/> Age Four	<input type="checkbox"/> Deceased	
<input type="checkbox"/> Adoption*	<input type="checkbox"/> No longer dependent for IRS purposes	COVERAGE LEVEL REQUESTED:
<input type="checkbox"/> Spouse's employment change	<input type="checkbox"/> No longer a full-time student	<input type="checkbox"/> Employee (only) <input type="checkbox"/> Employee/Children
<input type="checkbox"/> Part-time to full-time status	<input type="checkbox"/> Retirement	<input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Family
		<input type="checkbox"/> Employee/Child <input type="checkbox"/> Other _____

IMPORTANT! If your spouse works for The State of Maine or its Ancillary agencies, he or she is **NOT** eligible for coverage under your policy. Dual Dental Coverage is not allowed for State of Maine Employees.

4. DEPENDENT INFORMATION - List all dependents to be newly enrolled, or those dependents who are affected by an addition or deletion listed above in section #3. If you are enrolling some but not all of your eligible dependents, your other dependents must have coverage elsewhere.

LAST NAME (IF DIFFERENT FROM SUBSCRIBER)	FIRST NAME	DATE OF BIRTH	GENDER M/F	RELATION TO SUBSCRIBER	CHECK IF DEPENDENT IS OVER 19 AND A FULL-TIME STUDENT	*CHECK IF DEPENDENT IS INCAPACITATED

***NOTE: Legal documentation is required.**

5. OTHER GROUP COVERAGE (COORDINATION OF BENEFITS)

Will you, your spouse, or any dependent be covered under any other group dental plan while this policy is in effect? ☐ Yes ☐ No
Will this dental coverage replace another Northeast Delta Dental Plan? ☐ Yes ☐ No

If yes to either question, complete the following:

DENTAL INSURANCE COMPANY	POLICY HOLDER ID # / SOCIAL SECURITY #	EFFECTIVE DATE — —
DENTAL INSURANCE COMPANY	POLICY HOLDER ID # / SOCIAL SECURITY #	EFFECTIVE DATE — —

I certify that all information is true and correct to the best of my knowledge. I understand that by not choosing a network dentist for myself or any family member, I may be responsible for higher out-of-pocket expenses. I also understand that the effective date and termination date of my membership will be determined by my employer or plan sponsor in accordance with the underwriting guidelines of Northeast Delta Dental. If my employer or plan sponsor requires employee contributions for this coverage, I authorize the deductions of these amounts from my wages. I further authorize my employer or plan sponsor to deduct any dental premium which is owed by me as of the date my application is approved. I understand that my dependents and I must remain enrolled and can discontinue our coverage only during open enrollment, except in the event of a qualified family status change.

SIGNATURE _____ DATE _____

Election not to enroll (allowed for employees who work **less** than full time. Full time employees **can not** refuse coverage). I do not wish to enroll and understand the opportunity to enroll at any further date will be subject to regulations of the State of Maine group policy.

SIGNATURE _____ DATE _____